

FOR STATE
HEALTH DEPT.

TO DEPUTY EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A18ME
5M 9/60

STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooms Island</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooms Island</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Calvert County Hospital</u>						d. STREET ADDRESS <u>Unknown</u>					
3. NAME OF DECEASED (Type or print) <u>Collis</u> First <u>Lee</u> Middle <u>Coffey</u> Last						4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1966</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 18 36</u>		9. AGE (in years last birthday) <u>28</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Power Saw Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>				11. BIRTHPLACE (State or foreign country) <u>Lenoir, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Coffey</u>						14. MOTHER'S MAIDEN NAME <u>Ida Barnett</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>242-54-9974</u>		17. INFORMANT Address <u>Va. Wheeler-Thompson Funeral Home Fredericksburg</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shotgun wound, left pelvis</u> 9198 Conditions, if any, which gave rise to immediate cause (b) <u>DUE TO</u> (a), stating the underlying cause last. (c) <u>DUE TO</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Shot in pelvis</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot in pelvis</u>							
20c. TIME OF INJURY Month, Day, Year <u>7:50</u> Hour <u>2:20</u> p.m. <u>5/7 1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Car</u>		20f. (City or town) <u>Brooms Island</u> (County) <u>Calvert</u> (State) <u>Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <u>Werner U. Spitz, M.D.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						Address (Street, city, town, or county) <u>May 8 66</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/11/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Church Cemetery</u>		22d. LOCATION (City, town, or county) <u>Widewater, Va.</u>		(State) <u>-----</u>			
23. FUNERAL DIRECTOR ADDRESS <u>Balt. Md. 2120</u>						24a. REC'D BY REGISTRAR <u>MAY 11 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
Wm. Cook-Brooks Inc. 1217 St. Paul St											

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06713

CERTIFICATE OF DEATH

06707

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md. c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings, Maryland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Murio Last Chaney				4. DATE OF DEATH Month 5 Day 2 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/14/96	
9. AGE (In years last birthday) 70		10. UNDER 1 YEAR Months 11 Days 18 Hours 15 Min.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Samuel Chaney				14. MOTHER'S MAIDEN NAME Dora Ann Whittington			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-18-2796		17. INFORMANT Frederick Chaney Owings, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 4200 DUE TO (b) Arteriosclerosis that Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/24 , 19 66 to 5/1 , 19 66 , that (I) (we) last saw the deceased alive on 5/1 , 19 66 , and that death occurred at 8:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE Dr. Osman Ersoy				22b. DATE SIGNED 5/2/66		22c. PHYSICIAN'S NAME (Type) Dr. Osman Ersoy	
22d. ADDRESS Prince Frederick, Maryland				22e. ADDRESS Prince Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 4, 1966		23c. NAME OF CEMETERY OR CREMATORY Smithville Ch. Cem		23d. LOCATION (City, town or county) (State) Bunkirk Md.	
24. FUNERAL DIRECTOR Hutchins Funeral Home Owings Md.				25a. REC'D BY REGISTRAR MAY 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Jefferson City, Mo. 2. 1844

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06715

CERTIFICATE OF DEATH

06709

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b 6 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Calvert County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Plum Point d. STREET ADDRESS 04-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John		First John		Middle Emil		Last Fischer		4. DATE OF DEATH Month Oct Day 10 Year 1966	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/15/94		9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emil Fischer				14. MOTHER'S MAIDEN NAME Anthony Bastai					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Lucie Kelly		Address 6107 Eastern Ave. Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0021 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Pulmonary in suff - old T.B. DUE TO (c) cardiac failure									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1962 , 19 to May 11 , 19 66 , that (I) (we) last saw the deceased alive on 5-11-66 19 66 , and that death occurred at 11 M, from the causes and on the date stated above.									
22a. SIGNATURE Issam el Damalouji, M.D.				22b. DATE SIGNED May 16 1966					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Prince Frederick, Md.		22e. M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5/13/66		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR The Hines Co. 2901 14th St. N.W. Wash. DC.				25a. REC'D BY REGISTRAR MAY 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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00712 00702

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06716

06716

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Home, Hospital, or Institution) a. STATE <i>MD.</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>—</i>		e. STREET ADDRESS <i>—</i>	
3. NAME OF DECEASED (Type or print) First <i>Kelly</i> Middle <i>B.</i> Last <i>Foley</i>		4. DATE OF DEATH Month <i>May</i> Day <i>7</i> Year <i>1966</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2, 1962</i>
9. AGE (In years last birthday) <i>4</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles M. Foley</i>		14. MOTHER'S MAIDEN NAME <i>Shirley P. Foley</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs. Shirley P. Foley</i>		Address <i>Lusby Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> 325a DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>This pt was an idiot. Never talked, sat alone or drank.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H.W. Ward</i>		22. DATE SIGNED <i>5/7/66</i>	
EXAMINER'S NAME (Type) <i>H.W. Ward</i>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 9, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Calvert Bible Church Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Lusby Md.</i>	
24. FUNERAL DIRECTOR <i>AA. Harkness & Son</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
Address <i>Port Republic Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>MAY 10 1966</i>			

00318

00318

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06717

CERTIFICATE OF DEATH

06717

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md. c. LENGTH OF STAY IN 1b 23 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lower Marlboro, Maryland d. STREET ADDRESS 04-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rachel Ellen Gray		4. DATE OF DEATH Month Day Year 5 13 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/88
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days 13 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis Reid		14. MOTHER'S MAIDEN NAME Christianna Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Rebecca Gray		Address Owings, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Fracture left hip. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia, Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down at home accidentally	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Dr. Frederick Calvert Md.	
21. I certify that (I) (this hospital) attended the deceased from 4/20 , 19 66 , to 5/13 , 19 66 , that (I) (we) last saw the deceased alive on 5/12 , 19 66 , and that death occurred at 12:30 A. from causes and on the date stated above.			
22a. SIGNATURE Dr. Osman Ersoy		22b. DATE SIGNED 5/13/66	
22c. PHYSICIAN'S NAME (Type) Dr. Osman Ersoy		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-17-66		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Coopers Ch.Cem		23d. LOCATION (City or Town) (County) (State) Dunkirk Calvert Md	
24. FUNERAL DIRECTOR L.E. Sewell		ADDRESS Prince Frederick, Md	
25a. BY REGISTRAR MAY 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

11530

UNITED STATES DEPARTMENT OF AGRICULTURE

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C671S

CERTIFICATE OF DEATH

C6712

1 PLACE OF DEATH a. COUNTY Calvert County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md. c. LENGTH OF STAY IN 1b 2 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach, Maryland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Walter Elwood Koons		4 DATE OF DEATH Month Day Year May 18 19 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/7/864
9 AGE (In years last birthday) 88 yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles H. Koons		14. MOTHER'S MAIDEN NAME Elizabeth Salmon	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WWI		16 SOCIAL SECURITY NO. 578-05-8813	
17. INFORMANT Charles W. Koons		1331 G Street, N.W. Washington, D. C.	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9040 Heart Failure DUE TO (b) Fr. Hip - left DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Patient fell		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3/16 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) North Beach Calvert Md.	
21. I certify that (I) (this hospital) attended the deceased from 3-16- 19 66 , to May 18, 19 66 , that (I) (we) last saw the deceased alive on 5-18- 19 66 , and that death occurred at 2:30 P.M., from causes and on the date stated above.			
22a. SIGNATURE Issam el Damalouji, M.D.		22b. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 20, 1966	
23c. NAME OF CEMETERY OR CREMATORY St. Harmony Chr. Cemetery		23d. LOCATION (City or Town) (County) (State) Owings, Calvert, Maryland	
24. FUNERAL DIRECTOR Hutchins Funeral Home		25a. REC'D BY REGISTRAR MAY 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06719

CERTIFICATE OF DEATH

06719

1. PLACE OF DEATH a. COUNTY Calvert County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b one month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Calvert County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Broomes Island d. STREET ADDRESS Prince Frederick e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles First Mangold Middle May Last		4. DATE OF DEATH May Month 6 Day 19 Year 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 12/17/96		9. AGE (In years last birthday) 69 yrs.		10. UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Mangold		14. MOTHER'S MAIDEN NAME Lillian S. Mangold			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 182-07-7430		17. INFORMANT Mrs. Lillian S. Mangold Address land, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) = Circuass of liver (heart failure) 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21. I certify that (I) (this hospital) attended the deceased from May 5 , 19 66 , to May 6 , 19 66 , that (I) (we) last saw the deceased alive on May 5 , 19 66 , and that death occurred at 7:40 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Roberto de Villarreal		22b. DATE SIGNED 5/6/66		22c. PHYSICIAN'S NAME (Type) Dr. Roberto de Villarreal			
22d. ADDRESS St. Leonard, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 9, 1966		23c. NAME OF CEMETERY OR CREMATORY Broomes Island Cem.			
23d. LOCATION (City, town or county) Broomes Island, Md.		23e. (State) Md.					
24. FUNERAL DIRECTOR A. A. Harkness & Son		24a. ADDRESS Port Republic, Md.		24b. REC'D BY REGISTRAR Charles Judge			
24c. DATE MAY 10 1966		24d. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

06720

CERTIFICATE OF DEATH

06714

1 PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 15 days		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rose Haven, North Beach	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital			d. STREET ADDRESS Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) Rosie First Elizabeth Middle Marquess Last Rosa			4 DATE OF DEATH Month May Day 28 Year 1966		
5 SEX F	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/3/95	9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired		11 BIRTHPLACE (County & State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William Stallings		
14. MOTHER'S MAIDEN NAME Katie Marquess			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT James Buchanan Marquess, North Beach		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH 31 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/12 , 19 66 , to 5/28 , 19 66 , that (I) (we) last saw the deceased alive on 5/28 , 19 66 , and that death occurred at 7:55 AM , from causes and on the date stated above.					
22a. SIGNATURE Roberto deVillareal			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-28-66
22c. PHYSICIAN'S NAME (Type) R. deVillareal			22d. ADDRESS St. Leonard, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 30, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Chr. Cemetery	23d. LOCATION (City or Town) (County) (State) Owings Calvert Md.		
24. FUNERAL DIRECTOR Hutchins Funeral Home			25a. REC'D BY REGISTRAR JUN 2 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge

06721

CERTIFICATE OF DEATH

06715

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md. c. LENGTH OF STAY IN lb 45 days		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach, Maryland	
3. NAME OF DECEASED (Type or print) First Middle Last Louis J. Milbourne		4. DATE OF DEATH Month Day Year 5 23 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/93
10a. USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Lodowic Milbourne		14. MOTHER'S MAIDEN NAME Virginia Strickler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 577-03-4482	17. INFORMANT Mrs. Louise Milbourne Address same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 1992 IMMEDIATE CAUSE (a) Heart Failure DUE TO (b) Generalized Coronary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 to 5/23 , 19 66 , that (I) (we) last saw the deceased alive on 5/27 , 19 66 , and that death occurred at 6:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Osman Ersoy		22b. DATE SIGNED 5/23/66	
22c. PHYSICIAN'S NAME (Type) Dr. Osman Ersoy		22d. ADDRESS Prince Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 25, 1966	23c. NAME OF CEMETERY OR CREMATORY So. Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Dunkirk Calvert Maryland
24. FUNERAL DIRECTOR Hutchins Funeral Home		25a. REC'D BY REGISTRAR MAY 27 1966	
ADDRESS Owings, Maryland		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06722

CERTIFICATE OF DEATH

06716

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN IS 66 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Calvert County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admiss on) a. STATE Maryland b. COUNTY Anne Arundel ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairhaven d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara Natalie Padgett First Middle Last 4. DATE OF DEATH May 20 Month Day Year 19 66		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10/1/99 9. AGE (In years last birthday) 66 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmistress 10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C. 11. BIRTHPLACE (County & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Felix Seibert 14. MOTHER'S MAIDEN NAME Mary Van Doren	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 220-36-2072 17. INFORMANT Joseph F. Padgett, Fairhaven, Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral aneurysm + 42X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive CVR disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 16 , 19 66 , to May 20 , 19 66 , that (I) (we) last saw the deceased alive on May 20 , 19 66 , and that death occurred at 4 A M, from causes and on the date stated above.			
22a. SIGNATURE George J. Weems, M. D. 22c. PHYSICIAN'S NAME (Type) George J. Weems, M. D.		22b. DATE SIGNED 5/20/66 22d. ADDRESS Huntingtown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/23/66 23c. NAME OF CEMETERY OR CREMATORY St Marys Catholic 23d. LOCATION (City or town) (County) (State) Washington D. C.		24. FUNERAL DIRECTOR Hutchins Funeral Home Owings Md. 25a. REC'D BY REGISTRAR MAY 24 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

CS723

06717

1. PLACE OF DEATH a. COUNTY <u>Calvert</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>67 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Calvert County Hospital</u>		d. STREET ADDRESS <u>Prince Frederick</u>	
3. NAME OF DECEASED (Type or print) First <u>Denton</u> Middle <u>Lee</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/12/17</u>
9. AGE (in years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Howard Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. Elliott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-18-5876</u>	
17. INFORMANT <u>Denton Lee Smith, Prince Frederick, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Ca. isoplegus -</u> <u>150x</u> DUE TO (b) <u>(lower end)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 14, 1966</u> , to <u>May 19, 1966</u> , that (I) (we) last saw the deceased alive on <u>5/19/66</u> and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>5/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Roberto de Villarreal, M. D.</u>		22d. ADDRESS <u>St. Leonard, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 22, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Barstow, Calvert Co., Md.</u>	
24. FUNERAL DIRECTOR <u>O. O. Wickens & Son</u>		25a. REC'D BY REGISTRAR <u>May 23 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

06726

CERTIFICATE OF DEATH

06718

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 53 das.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach 64-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Cobb Last Snider		4. DATE OF DEATH Month May Day 16 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/15
9. AGE (In years last birthday) 51 yrs		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (County & State, or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Cobb		14. MOTHER'S MAIDEN NAME Dora Orr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 491-03-1465	
17. INFORMANT Snider - husband		18. ADDRESS Louis R. Snider North Beach, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO Generalized Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Poison of Rt Breast (b) Poison of Rt Breast (c) Poison of Rt Breast		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 11 , 19 65 , to 5/16 , 19 66 , that (I) (we) last saw the deceased alive on 5/16 , 19 66 , and that death occurred at 8:10 P.M. , from causes and on the date stated above.			
22a. SIGNATURE O. Z. Ersoy		22b. DATE SIGNED 5/17/66	
22c. PHYSICIAN'S NAME (Type) O. Z. Ersoy, M.D.		22d. ADDRESS Prince Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/19/66	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or Town) (County) (State) Suitland Md
24. FUNERAL DIRECTOR Lee Funeral Home		25a. REC'D BY REGISTRAR MAY 19 1966	
ADDRESS Washington, D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06725

CERTIFICATE OF DEATH

06719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove companion papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>CALVERT</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>PR. FREE.</u>		c. LENGTH OF STAY IN 1b <u>9 DAYS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANS ROAD</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CALVERT NURSING HOME</u>		d. STREET ADDRESS <u>RT #1, Box 133A</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>SPILMAN</u> Last <u>ELLIS</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1966</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JULY 12, 1884</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>
12. CIT. ZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>ELLIS</u>	
14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Box 133A RT #1</u> <u>VIRGINIA JOHNSON BRYANS RD MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4341</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO <u>congestive heart failure</u>			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>5-23-66</u> , 19 <u> </u> , to <u>5-30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u>12:55 M.</u> from causes and on the date stated above.	
22a. SIGNATURE <u>Isam A. El. Jamilouli</u>		22b. DATE SIGNED <u>5-31-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Isam A. El. Jamilouli</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-3-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>ROCKVILLE MD</u>
24. FUNERAL DIRECTOR <u>Wm. Chambers</u>		25a. REC'D BY REGISTRAR <u>3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>517 11th St SE</u>	



06726

CERTIFICATE OF DEATH

06720

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut or Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hosptial		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Willis Stertz		4. DATE OF DEATH Month Day Year 5 31 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/21
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stertz		14. MOTHER'S MAIDEN NAME Emma Oldenburg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO 507-16-5525	
17. INFORMANT Mrs. Anne C. Stertz		Address Prince Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ca. of the bowels, small and large with Metastasis DUE TO (b) - DUE TO (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-3-65 , 19__, to 5-31-66 , 19__, that (I) (we) las saw the deceased alive on 5-31-66 , 19__, and that death occurred at 10:PM , from causes and on the date stated above			
22a. SIGNATURE Damalouji		22b. DATE SIGNED 6/1/66	
22c. PHYSICIAN'S NAME (Type) Dr. Issam F. Damalouji		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 4, 1966	23c. NAME OF CEMETERY OR CREMATORY Central Cemetery	23d. LOCATION (City or Town) (County) (State) Barstow, Calvert Maryland
24. FUNERAL DIRECTOR Hutchins Funeral Home		25a. REC'D BY REGISTRAR JUN 6 1966	
ADDRESS Wings, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and ~~may~~ event, within 72 hours after death.

VR A15 (4)
20 M 1/66



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>06721</p> </div> <div> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>06721</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Dunn</i> c. LENGTH OF STAY IN 1b <i>10</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Wash DC</i>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>Calvert</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>1331 Valley Road SE</i> d. STREET ADDRESS <i>Wash DC</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>James Walter Taylor</i> First Middle Last						4. DATE OF DEATH <i>5/13</i> Month Day Year <i>1966</i>					
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/21/42</i>		9. AGE (In years last birthday) <i>23</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Guard</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>goddard force agency</i>				11. BIRTHPLACE (State or foreign country) <i>Maine</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Paul A. Taylor</i>						14. MOTHER'S MAIDEN NAME <i>Edith M. Perkins</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <i>8164</i>		17. INFORMANT <i>Paul A. Taylor (father) as #2</i> Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broken neck, crushed skull</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Car rolled over on today</i> (c) <i>Car accident - 2 cars - Was thrown from car</i>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Car rolled over on today</i>							
20c. TIME OF INJURY Month, Day, Year, Hour <i>9:30 p.m. 5/13/66</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>260</i>		20f. (City or town) <i>Dunn</i> (County) <i>Calvert</i> (State) <i>MD</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>H W Ward</i>						22. DATE SIGNED <i>5/13/66</i>					
EXAMINER'S NAME (Type) <i>H W. WARD</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Wash DC</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>May 17-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery - Arlington, Virginia</i>				23d. LOCATION (city, town or county) (State) <i>Wash DC</i>	
24. FUNERAL DIRECTOR <i>Simmons Brothers</i> ADDRESS <i>1661- Gd. Hope Rd. SE DC</i>						25a. REC'D BY REGISTRAR <i>MAY 17 1966</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Loudoun</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Herndon</u>	
c. LENGTH OF STAY IN 1b <u>3 years</u>		d. STREET ADDRESS <u>H.F. 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Larry</u> Last <u>Thraese</u>		4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30 1881</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Colusa California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Thraese</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Copsy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>223-50-6421</u>	
17. INFORMANT <u>Guy L. Thraese Jr.</u>		Address <u>Salmons, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cholera</u> 4201 DUE TO (b) <u>Cranial occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>High</u>	20f. (City or town) (County) (State) <u>MD</u>
21. I certify that (I) (this hospital) attended the deceased from <u>May 9</u> , 19 <u>66</u> , to <u>May 9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 9</u> , 19 <u>66</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Roe Villareal</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Roe Villareal</u>		22d. ADDRESS <u>St Leonard, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>May 11, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Herndon Va.</u>
24. FUNERAL DIRECTOR <u>A.A. Harkness</u>		25a. REC'D BY REGISTRAR <u>May 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1973

03730

MAY 11 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06729

06723

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick, Md.</u> c. LENGTH OF STAY IN 1b <u>46 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendship, Maryland</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Daugherty</u> Last <u>Wells</u>		4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/11/89</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Daugherty</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Mason</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-46-5686</u>	
17. INFORMANT <u>Elizabeth Windland</u>		Address <u>Friendship, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 593x DUE TO (b) <u>Bright's disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 7, 1966</u> to <u>May 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 7, 1966</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Roberto Villarreal</u>		22b. DATE SIGNED <u>5/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Roberto Villarreal</u>		22d. ADDRESS <u>St. Leonard, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 12, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Friendship Md.</u>	
24. FUNERAL DIRECTOR <u>Hutchins Funeral Home</u>		25a. REC'D BY REGISTRAR <u>May 13 1966</u>	
ADDRESS <u>Owings, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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